

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-043813

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

6173

FILED DEC - 2 1963

1. PLACE OF DEATH

a. COUNTY Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN Kansas City

Length of stay in 1b
45 years

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION 3725 Locust

Inside Limits
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)
3725 Locust

Inside Limits
Yes ☒ No ☐

Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED

(Type or print)

First William

Middle D.

Last Bush

4. DATE OF DEATH

Month November

Day 13

Year 1963

5. SEX
Male

6. COLOR OR RACE
Caucasian

7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐

8. DATE OF BIRTH
9-8-1888

9. AGE (last birthday)
75

IF UNDER 1 YEAR IF UNDER 24 HR.
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Lawyer

10b. KIND OF BUSINESS OR INDUSTRY
Law Practice

11. BIRTHPLACE (City and state or country)
Saline County, Mo

12. CITIZEN OF WHAT COUNTRY
USA

13a. FATHER'S NAME

William D. Bush

13b. MOTHER'S MAIDEN NAME

Ruth Thompson

14. NAME OF HUSBAND OR WIFE

Mabel C. Bush

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.

Byron Bush

17. INFORMANT Address 7901 Arlington

Raytown, Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pneumonia -
Myocardial failure -
Chronic myocarditis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Generalized arteriosclerosis

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☐

20a. ACCIDENT SUICIDE HOMICIDE
☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from
Death occurred at 2:00 PM

Sept. 63 to Nov. 63 and last saw her alive on Nov 11 63

22a. SIGNATURE

(Deceased or title)

22b. ADDRESS

3900 Pacer Home

22c. DATE SIGNED

11/13/63

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

23b. DATE

11-15-1963

23c. NAME OF CEMETERY OR CREMATORY

Floral Hills

23d. LOCATION (City, town, or county)

Kansas City, Missouri

(State)

24. FUNERAL DIRECTOR

Floral Hills Funeral Home
Kansas City, Mo.

ADDRESS

25. DATE RECD. BY LOCAL REG.

11-13. 63

26. REGISTRAR'S SIGNATURE

Bessie Smith

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

James E. Griffin Medical Certification

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.